COMMUNICABLE DISEASE REPORT
SEXUALLY TRANSMITTED DISEASES

-Send to Local Health Department-

PATIENT NAME - Last, First, Middle

☐ Male ☐ Female ☐ Trans-gender

ETHNICITY ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

ADDRESS - Street

DOB

RACE ☐ White ☐ Black ☐ American Indian ☐ Native Hawaiian or Other Islander ☐ Asian ☐ Other

TOWN - CITY STATE ZIP CODE

PHONE NO. ( )

Diagnosis

☐ **Chlamydia**

☐ **Gonorrhea**
- ☐ PID
- Other: _____

☐ **Syphilis**
- ☐ Primary
- ☐ Secondary
- ☐ Early Latent
- ☐ Late (> one year)
- ☐ Congenital
- ☐ Other Syphilis

Specify_____

Other STDs
- ☐ Herpes
- ☐ Chancroid

Lab Results

Date	Test	Result
/ /		
/ /		
/ /		

Treatment

Date	Drug	Dosage
/ /		
/ /		
/ /		

Site of Infection: ☐ Genitalia ☐ Rectum ☐ Throat ☐ Other _____

Patient had sexual contact with: ☐ Males only ☐ Females only ☐ Both ☐ Refused ☐ Unknown

Reporting Facility Address Town - City State ZIP

Clinician Phone ( ) -

Is patient pregnant? ☐ Yes ☐ No

Was diagnosis confirmed by a laboratory? ☐ Yes ☐ No

If Yes, list lab

Original and First Copy to County/Tribal Health Department ➡ **http://www.hs.state.az.us/phs/oids/std/county_contact.htm**